

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035031

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

4937

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 35 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSPITAL		d. STREET ADDRESS (If outside, give location) 9615 MADISON AVENUE	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY LOUISE VAN SCOY		4. DATE OF DEATH Month Day Year SEPTEMBER 25 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/14/04
9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MANAGER		10b. KIND OF BUSINESS OR INDUSTRY CARNIE-GOUDIE AWNING COMPANY	
11. BIRTHPLACE (City and state or country) HEPBURN, IOWA		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME WALTER W. WEST		13b. MOTHER'S MAIDEN NAME LOUISE BEUCLER	
14. NAME OF HUSBAND OR WIFE K. E. VAN SCOY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Address 9615 MADISON AVE. K. E. VAN SCOY KANSAS CITY, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis Primary carcinoma lt. breast Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr + 4 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from July 9, 1958 to Sept 25, 1962 and last saw her alive on Sept. 24, 1962 Death occurred at 6:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Neill BERRY, MD	22b. ADDRESS 4320 Wornall Rd	22c. DATE SIGNED 9-25-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT. 27, '62	23c. NAME OF CEMETERY OR CREMATOR MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 9-27-62	26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Neill BERRY

OCT 23 1962

H. Neill Breen  
Unit 336 - 4320 Hammett Road  
3.00 - 4.00

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond M. Hardy

Licensed Embalmer No. 4913

P. O. Address Indep. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.